New Patient Information

Date: _____/_____/_____

*First Name_____ *Last Name_____

Address: _____

City: _____ State: _____ Zip code: _____

Cell Phone: (_____) _____-_____

Other Phone: (_____) _____-_____

*Email Address: _____

*Birthdate:_____/_____/_____ Male ☐ Female ☐

How did you hear about us?

Online: ____ Saw an AD: ____

Referral: ____ If yes, who referred you? _____

Other: ____ If yes, please specify: _____

Reason for visit?

_____

_____

_____

HIPAA INFORMATION RELEASE AUTHORIZATION

Effective starting (Today's Date) _____/_____/_____. In accordance with the new HIPAA privacy laws, Free Motion Physical Therapy can no longer discuss any protected health information with any person other than the patient, doctor, insurance company and/or specified person(s). If you would like your information released to your spouse or any other person, you need to sign a records release form. We appreciate your cooperation in helping maintain patient confidentiality.

_____

I, (Name) _____ hereby authorize Free Motion Physical Therapy to release any information (if necessary), including reminders of appointments, the diagnosis and records of any treatment, examination, or evaluation rendered to the undersigned patient, and all financial records to:

Name of person(s):	Relationship to patient:
1._____	_____
2._____	_____
3._____	_____

Patient signature: x_____ Date: _____

HIPAA Privacy Practices Acknowledgement

I acknowledge and understand that Free Motion follows the HIPAA Privacy Act to keep my info secure and that at any time I can request a copy of the HIPPA Patient Privacy notice.

_____ _____

Signature Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I, (the undersigned), hereby authorize my physician, hospital, clinic, or other medical institution to furnish Free Motion Physical Therapy of Clearwater, FL, all information you may have regarding my condition while under your observation and/or treatment; including the history obtained, x-rays, physical findings, diagnosis and prognosis. In addition, I authorize any attending physician, medical professional, hospital or other medical care facility or service to discuss with and/or provide reports to Free Motion Physical Therapy regarding my diagnosis, treatment, care, physical condition and prognosis.

I, (the undersigned), hereby authorize Free Motion Physical Therapy to release any medical information or documentation that has been obtained or created on my behalf to Medicare, Medicaid, or any other third party insurance for the purpose of reimbursement. I, (the undersigned), also authorize the release of my treatment and/or history obtained to my physician of record.

I, (the undersigned), hereby instruct and direct Medicare, Medicaid, or any other third party insurance company to pay by check, made payable and mailed to Free Motion Physical Therapy all funds for the reimbursement of professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered.

I acknowledge that THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a timely manner, any charges on my account with Free Motion and also any deductible or co-pay charges, as defined by my individual insurance policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I, (the undersigned), hereby authorize Free Motion Physical Therapy to initiate a complaint to the Insurance Commissioner, for any reason, on my behalf.

I, (the undersigned), understand that I may revoke this authorization, in writing, to Free Motion Physical Therapy at any time.

I (the undersigned) attest that I have read and understand all of the above authorizations.

x_____ Date:_____

Patient/ Parent / Authorized Guardian (**circle one)**

MEDICAL HISTORY

Do you have a history of any of the following? Please circle "Yes" or "No".

1. Allergies	Yes	No	6. Diabetes	Yes	No	13. High blood pressure	Yes	No
			7. Digestive disorder	Yes	No	14. High Cholesterol	Yes	No
			8. Dizziness	Yes	No	15. HIV	Yes	No
2. Arthritis	Yes	No	9. Epilepsy	Yes	No	16. Numbness	Yes	No
3. Asthma	Yes	No	10. Headaches	Yes	No	17. Stroke	Yes	No
4. Cancer	Yes	No	11. Heart problems	Yes	No	*Notes regarding any yes answers:*		
5. Clotting disorder	Yes	No	12. Hepatitis	Yes	No			

Do you smoke? Yes No If yes, how many packs per week? _____ For how many years?

Do you drink alcohol? Yes No If yes, how much per week?

Recreational drug use? Yes No Describe: _____

Do you have any STDs? Yes No If yes, explain:_____

Do you exercise regularly? Yes No How often? _____

Do you have any metal implants? Yes No Describe: _____

Do you have a cardiac pacemaker? Yes No How long have you had it? _____

Are you allergic to any medications? Yes No List: _____

Adverse reactions to any medications? Yes No List: _____

Please list any medications you are currently taking: _____

Please list all surgeries, major illnesses and/or injuries and the year of their occurrence:

_____

_____

Are you pregnant? _____ Please list any childbirth experiences you have had: _____

Who is your referring physician? _____ Who is your primary care physician? _____

IN CASE OF EMERGENCY

Notify: _____ Relationship: _____

Phone number: (C) _____ (W) _____ (H) _____

I have completed this form to the best of my knowledge and find the information to be true and accurate.

Patient/ Parent/ Guardian signature: _____ Date: _____

INSURANCE/ PAYMENT/ CANCELLATION POLICY

Insurance

Free Motion Physical Therapy does **not** accept any form of insurance or Medicare. We will provide you with a superbill at the end of your service if requested for submitting of your bills for possible reimbursement. *(if you have questions, please ask the receptionist)*

Payment for Services Rendered

All services are expected to be paid for in full at the end of every appointment, unless pre-approved in writing by the owner or executive. (If you are currently unaware of the exact price of your service, please ask the Receptionist for pricing information immediately)

Cancellation Policy

Our Therapists time is very valuable and in high demand. We understand things can come up where you need to reschedule, should you need to cancel an appointment, you must provide a minimum of a 24 hour notice through text or call.

If you ***do not*** notify us within 24 hours there will be a ***$50.00*** balance on your account to be paid at your next visit.

I, (print name) _____ hereby state that I have read and fully understand the above statement.

Signature: _____ Date: _____

CONDITION HISTORY

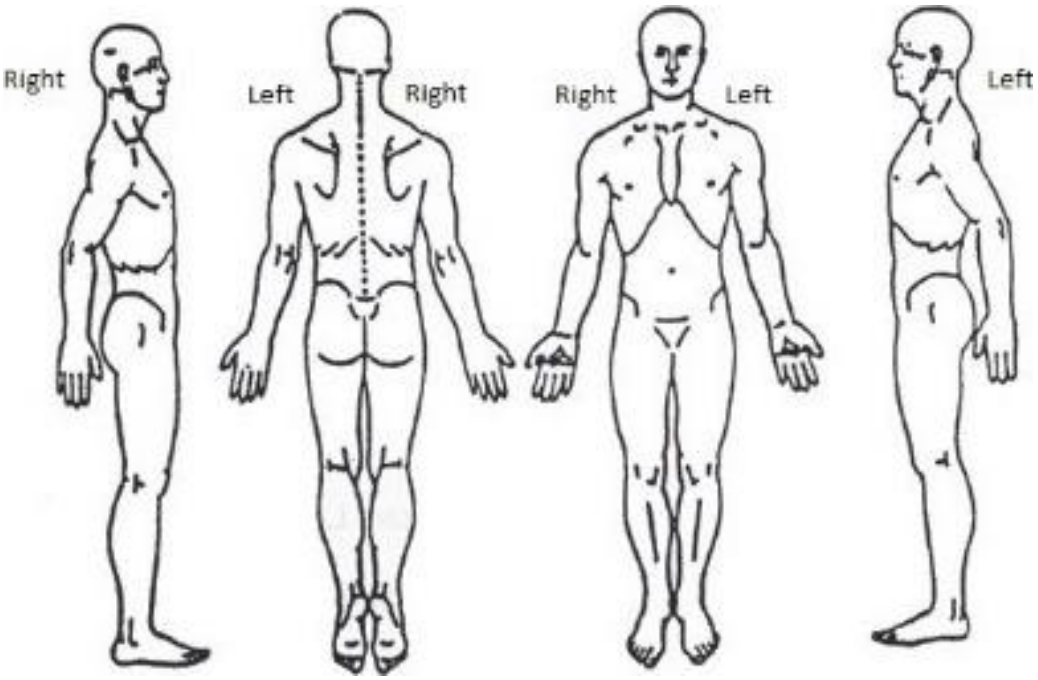
Please answer the following questions. Please describe when appropriate.

1. What is the reason for this visit? _____
2. How did this condition start? _____
3. When did this condition start? _____
4. What treatments have you had for this? _____
5. Have you had physical therapy for this before? _____
6. Any tests or procedures done regarding this? If so, what were the results? _____

_____

_____

On the diagram below, please indicate where you are experiencing your pain or altered sensation by labeling the affected areas. Use the letter key to the right and be as specific as possible.



A = Achiness
B = Dull pain
P = Sharp pain
B = Burning pain
T = Tingling
N = Numbness
S = Stiffness

On the scale below, please rate your MAXIMUM and MINIMUM pain over the past week. ***0= No Pain 10= Lots of Pain***

0 1 2 3 4 5 6 7 8 9 10

Is your pain constant? Y / N

What increases your pain? _____

What decreases your pain? _____

Signature: _____ Date: _____